Complete Summary

GUIDELINE TITLE

(1) Clinical practice guideline for the management of cataract among adults. (2) Updated recommendation #14.

BIBLIOGRAPHIC SOURCE(S)

Philippine Academy of Ophthalmology. Clinical practice guideline for the management of cataract among adults. Philippines: Philippine Academy of Ophthalmology; 2001. 27 p. [73 references]

Philippine Academy of Ophthalmology. Clinical practice guidelines for the management of cataract among adults. Updated recommendation #14. Philipp J Ophthalmol 2005 Apr-Jun;30(2):95-6. [9 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On April 7, 2005, the U.S. Food and Drug Administration (FDA) asked manufacturers of non-prescription (over the counter [OTC]) non-steroidal anti-inflammatory drugs (NSAIDs) to revise their labeling to include more specific information about potential gastrointestinal (GI) and cardiovascular (CV) risks, and information to assist consumers in the safe use of the drugs. See the FDA Web site for more information.

Subsequently, on June 15, 2005, the FDA requested that sponsors of all NSAIDs make labeling changes to their products. FDA recommended proposed labeling for both the prescription and OTC NSAIDs and a medication guide for the entire class of prescription products. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Cataracts

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Ophthalmology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

2001 Guideline

To provide a general approach to the management of adult patients suspected of having cataracts with or without functional impairment

2005 Addendum

To assess the current validity of Recommendation #14, which states that both phacoemulsification and extracapsular cataract extraction (ECCE) are acceptable techniques among patients undergoing cataract surgery

TARGET POPULATION

Adult patients suspected of having cataracts with or without functional impairment

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnostic Assessment and Initial Management

1. Medical history including age, the presence of hereditary factors, trauma, inflammation, metabolic or nutritional disorders or exposure to radiation, and patient's assessment of degree of visual impairment and its impact on quality of life
2. Physical examination to confirm the presence of cataract and to examine the presence of other conditions or prognostic factors that may complicate visual impairment and outcome of cataract management
3. Objective tests including funduscopy, Snellen's visual acuity testing, and pinhole testing
4. Cataract classification based on use of the Snellen's far and near visual testing
5. Patient education regarding cataract formation and progression, modifiable risk factors, and risks and benefits of surgical and non-surgical treatments
6. Initial non-surgical treatment including changing a spectacle or contact lens prescription, incorporating filters into the spectacles or wearing brimmed hats or sunglasses to decrease glare
7. Referral to an ophthalmologist as required
8. Slit lamp examination, dilated funduscopy, and tonometry (by ophthalmologist)
9. Contrast glare sensitivity tests as indicated (by ophthalmologist)
10. Differential diagnoses such as error of refraction, corneal opacities, glaucoma, retinopathy, and age-related macular degeneration should be ruled out
11. Surgical referral as required

Preoperative Management

1. Obtaining informed patient consent
2. Preoperative testing including keratometry, biometry, lacrimal apparatus irrigation
3. Preoperative workup for patients symptomatic or at high risk of developing cardiopulmonary complications

Surgical Management

1. Phacoemulsification, manual phacofragmentation, or extracapsular cataract extraction (note: intracapsular cataract extraction is considered but not recommended)
2. Implantation of an intraocular lens (silicone, acrylic, polymethylmethacrylate, hydrogel)
3. Local anesthesia including topical bupivacaine plus intravenous midazolam and fentanyl; intravenous methohexital followed by retrobulbar block consisting of lidocaine, bupivacaine, and hyaluronidase; peribulbar injections; and subconjunctival anesthesia
4. General anesthesia as indicated
5. Outpatient surgery (versus in-patient)
6. Second eye surgery as required

Post-Operative Management

1. Use of topical antibiotics, topical nonsteroidal anti-inflammatory drugs, (e.g., diclofenac, ketorolac), or topical corticosteroids (e.g., prednisolone, prednisolone acetate, dexamethasone)
2. Post-surgical follow-up including refractive evaluation

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic instruments
- Visual acuity
- Vision-related quality of life
- Prevention of progression
- Intraoperative and post-operative complications
- Incidence of adverse drug effects

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

2001 Guideline

An electronic search using MEDLINE, OVID, Cochrane, and other Internet resources was conducted to search for clinical studies limited to humans, any language, and all journal publications from 1966 to the present. The citations generated by the searches were examined for relevance to the questions generated on the basis of article titles and/or clinical abstracts available. To supplement the electronic search, references of the full-text articles retrieved were reviewed for other publications that might be relevant to the questions at hand and their own full-text articles retrieved. A manual search of the journals "British Journal of Ophthalmology," "American Journal of Ophthalmology," "Archives of Ophthalmology," and "Ophthalmology" dated 1997 to the present was done to retrieve other relevant articles that could have been missed by the previous search strategies. In addition, the Philippine Academy of Ophthalmology and the Philippine Health Insurance Corporation also submitted a few items not previously identified through the systematic literature review and if deemed to be relevant these were included.

2005 Addendum

The guideline developers reran the search for primary studies comparing extracapsular cataract extraction (ECCE) to phacoemulsification from January 2001 to August 2005. Trials were identified from the Cochrane Controlled Trials Register--CENTRAL/CCTR (which contains the Cochrane Eyes and Vision Group trials register) on the Cochrane Library and MEDLINE. See the technical review (in the "Companion Documents" field) for details of the search strategy.

NUMBER OF SOURCE DOCUMENTS

2001 Guideline

Not stated

2005 Addendum

Two new metaanalyses and one prospective randomized controlled trial were identified, retrieved, and appraised. Two trials comparing the costs and benefits of extracapsular cataract extraction (ECCE) with those of manual small-incision cataract surgery were included to introduce the latter technique as an additional option in addressing the cataract backlog in the Philippines.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Delphi Method)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

A systematic assessment of the validity of the retrieved full-text articles was done using the appropriate critical appraisal guides formulated by the Family Medicine Research Group which was a modification of the user's guide of the Evidence-Based Medicine Working Group. Separate guide questions were used for articles on (a) diagnosis, (b) differential diagnosis, (c) harm and causation, (d) prognosis, (e) therapy or prevention, (f) meta-analysis and (g) clinical practice guideline.

Recommendations were then graded according to the strongest evidence found following the Canadian Task Force on Preventive Health Care grading of recommendations.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Delphi)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

2001 Guideline

The Family Medicine Research Group and the Technical Research Panel of the Philippine Academy of Ophthalmology formulated an initial draft. The draft was sent to individual members of the Family Medicine Research Group and the Technical Committee of the Philippine Academy of Ophthalmology for comments and revisions. The final version of the guideline was made after two rounds of consensus using the Delphi method.

2005 Addendum

Using the conceptual model developed by the US Agency for Healthcare Research and Quality, the guideline developer evaluated Recommendation #14 to determine whether it should be updated or withdrawn. Accordingly, an update was warranted under any of the following circumstances:

1. New preventive, diagnostic, or treatment interventions may have emerged to complement or supersede other interventions.
2. New evidence may require updating of the estimates of benefits and harm for existing interventions.
3. New evidence may identify as important outcomes that were previously unappreciated or wholly unrecognized.
4. Evidence that current practice is optimal may change.
5. The values that individuals or society place on different outcomes may change over time.
6. The resources available for health care may change significantly.

Updating the guideline recommendation was done in two stages: (1) identifying significant new evidence by conducting a systematic review of the literature, and (2) assessing whether the new evidence warrants updating or withdrawal by using the Delphi method in soliciting the opinion of experts from the original panel that developed the guidelines.

Identified evidence was used to assess the current validity of Recommendation #14. These results were used to classify the recommendation into one of the following categories:

1. Withdraw. New evidence called into question one or more key therapeutic recommendations, or new evidence suggested the need for new key therapeutic guideline recommendations.
2. Retain, append new evidence. Key therapeutic recommendations were still valid, but new evidence supported changes to other recommendations, or supported greater refinement of existing recommendations.
3. Retain. The guideline continued to represent good clinical care.

Based on the results of the identified evidence, Recommendation #14 was thus classified as Retain, append new evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A. Good evidence (at least 1 properly conducted randomized controlled trial) to support the recommendation that the alternative be specifically considered.
B. Fair evidence (evidence from well designed controlled trials without randomization, from well designed cohort or case control studies, comparisons between times and places) the recommendation that the alternative be specifically considered.
C. Poor evidence (descriptive studies, experts' opinion) regarding inclusion or exclusion of the alternative, but recommendations may be made on other grounds.
D. Fair evidence (at least 1 properly conducted randomized controlled trial) to support the recommendation that the alternative be specifically excluded from consideration.
E. Good evidence (evidence from well designed controlled trials without randomization, from well designed cohort or case control studies, comparisons between times and places) the recommendation that the alternative be specifically excluded from consideration.

COST ANALYSIS

2001 Guideline

A group of researchers in a 1998 cost-benefit study comparing phacoemulsification and extracapsular cataract extraction (ECCE) reported that patients undergoing phacoemulsification presented a frequency of intra- and postoperative complications lower than those undergoing ECCE (odds ratio 0.57, 95%CI 0.37-0.87 and 0.66, 95%CI 0.46-0.96, respectively), specifically for intraoperative iris trauma (3.1% vs. 0.3%, p = 0.004), residual posterior capsular opacity (2% vs. 0.3%, p = 0.035) and postoperative corneal edema (7.4% vs. 3.6%, p = 0.016). Costs of intervention and follow-up were lower for phacoemulsification compared with ECCE (23.9% and 14%, respectively). But global costs were slightly higher for phacoemulsification (4.87%), due to supply costs, which were more than twice those of ECCE. The study went on to conclude that phacoemulsification, when performed by an experienced surgeon, has better clinical outcomes than planned extracapsular extraction, and costs may be lower since supply costs are expected to decrease as the phacoemulsification technique becomes more widespread.

2005 Addendum

Additional cost-benefit trials for ECCE were reviewed for this addendum.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

2001 Guideline

Not stated

2005 Addendum

The proposed revision was sent to all members of the original panel for approval. Among the 21 members of the original panel that developed the guidelines, 15 responded. All (100%) agreed to retain and update Recommendation #14 by appending new evidence. The remaining six (29%) were not able to submit their response in time for this update.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC) and the Philippine Academy of Ophthalmology (PAO): To ensure the validity of their guidelines, the PAO Evidence-Based Ophthalmology (EBO) group has initiated the review of the cataract clinical practice guideline released in 2001. However, since the process of updating the entire set of guidelines can be very costly and time consuming, the group shall tackle this task by evaluating the document in sections, prioritizing recommendations that are deemed outdated in reference to changes in the evidence, available resources, and values placed on outcomes. In this update, they have prioritized the review of Recommendation #14 for the Management of Cataract among Adults that states that both phacoemulsification and extra capsular cataract extraction (ECCE) are acceptable techniques among patients undergoing cataract surgery. The EBO concluded that the recommendation should be retained, and relevant new information for clinicians has been included in the original guideline document.

The recommendation grades (A-E) are defined at the end of the "Major Recommendations" field.

Definition

Recommendation 1

In medical practice, cataract is defined as any opacity of the lens that may or may not be associated with visual problems and manifest as an obstruction of the red orange reflex on funduscopy. (Grade C Recommendation)

Recommendation 2

In medical practice the objective of management of cataract is (a) correction of visual impairment, (b) maintenance of quality of life, and (c) prevention of progression. (Grade C Recommendation)

Classification

Recommendation 3

In family practice cataract should be classified according to types based on visual impairment using the Snellen's far and near visual testing. The classification types are the following (Grade C Recommendation):

- Type I - is characterized by patients with visual acuity better than 20/40 in the affected eye/eyes
- Type II - is characterized by patients having visual acuity of 20/40 or worse in the affected eye/eyes

Physical Examination

Recommendation 4

In family practice, funduscopy (Grade C Recommendation), visual acuity testing and pinhole (Grade B Recommendation) should be done for all patients suspected to have cataracts.

Recommendation 5

For patients suspected of having cataracts, slit lamp examination, dilated funduscopy and tonometry should routinely be done in ophthalmologic practice. (Grade C Recommendation)

Diagnostic Procedures

Recommendation 6

For patients with suspected cataract whose visual acuity is 20/40 or better but referred to ophthalmology for further evaluation contrast glare sensitivity may be done to detect potential problems in nighttime vision. (Grade C Recommendation)

Differential Diagnosis

Recommendation 7

Among patients suspected of having cataracts, the following causes of visual impairment should be ruled out: (a) error of refraction, (b) corneal opacities, (c) glaucoma, (d) retinopathy, and (e) age-related macular degeneration. (Grade B Recommendation)

Prognostic Factors

Recommendation 8

Among patients with cataracts, the following socio-demographic characteristics need to be elicited because it leads to poorer outcomes: (a) age, (b) sex, (c) social strata, (d) education, and (e) race. (Grade B Recommendation)

Recommendation 9

The following clinical entities such as: (a) diabetes, (b) hematologic disorders, (c) rheumatoid disorders, (d) alcohol abuse, (e) ocular trauma and concomitant ocular symptoms, (f) myopia/high error of refraction (EOR), and (g) steroid use should also be elicited because they also lead to poor outcomes. (Grade B Recommendation)

Surgical Approach to Management

Recommendation 10

Among patients with cataracts, any one of the following may be an indication for surgery: (a) patient's preference and needs, (b) functional disability as measured by Snellen's visual acuity test and modified visual field-14 (VF-14), (c) cataracts with concomitant ocular problems. (Grade C Recommendation)

Recommendation 11

Prior to cataract surgery, the patient must be informed about the benefits, possible side effects and complications, and costs of available alternative surgical and anesthesia procedures. (Grade C Recommendation)

Recommendation 12

Pre-operatively, keratometry, biometry, lacrimal apparatus irrigation (LAI) should routinely be done.

Recommendation 13

Among healthy adult patients scheduled for cataract surgery under local anesthesia, no routine preoperative medical testing is necessary. (Grade A Recommendation)

For patients who are symptomatic and are at high risk of developing cardiopulmonary complications, pre-operative work-up may be done. (Grade C Recommendation)

Recommendation 14 (2005 Update)

Among patients undergoing cataract surgery, small incision surgery (either by phacoemulsification or manual phacofragmentation) and extracapsular cataract extraction (ECCE) are acceptable techniques. (Grade A Recommendation)

Recommendation 15

Among patients who will undergo cataract extraction, implantation of an intraocular lens is recommended. (Grade A Recommendation)

Recommendation 16

While local anesthesia is recommended in majority of patients undergoing cataract surgery, general anesthesia may be used when indicated. (Grade A Recommendation)

Recommendation 17

Among patients who will undergo cataract extraction, surgery on an out-patient basis is recommended. (Grade B Recommendation)

Recommendation 18

Indications for second eye surgery in those with bilateral cataracts are the same as for the first eye. Timing of second eye surgery is best discussed by the surgeon and the patient; however, simultaneous cataract extraction is not recommended. (Grade C Recommendation)

Recommendation 19

Post-operatively, topical antibiotics, steroids, or nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended. (Grade A Recommendation)

Recommendation 20

Post-surgery, close follow-up with refractive evaluation of the patient is recommended until best corrected vision achieved. (Grade C Recommendation)

Non-Surgical Options

Recommendation 21

Non-surgical management is recommended in the following conditions; (1) patient's refusal of surgery, (2) no visual disability, (3) best correction results in satisfactory visual function, and (4) surgery is unlikely to improve visual function. (Grade C Recommendation)

Recommendation 22

Refraction that affords the best visual function together with patient education is the only non-surgical option for cataract patients. (Grade C Recommendation)

Health Education

Recommendation 23

Patient education should include the following; (1) advice on modifiable risk factors, (2) advice on eventual need for surgery for non-surgical patients, (3) advice on all available surgical procedures and outcomes, and (4) advice that to date no medications have been proven to retard the progression of age-related cataracts. (Grade C Recommendation)

Referral

Recommendation 24

Patients with Type II cataracts and those with Type I suspected of having other ocular blinding conditions should be referred to an ophthalmologist. (Grade C Recommendation)

Definitions:

Grades of Recommendations

A. Good evidence (at least 1 properly conducted randomized controlled trial) to support the recommendation that the alternative be specifically considered
B. Fair evidence (evidence from well designed controlled trials without randomization, from well designed cohort or case control studies, comparisons between times and places) the recommendation that the alternative be specifically considered.
C. Poor evidence (descriptive studies, experts' opinion) regarding inclusion or exclusion of the alternative, but recommendations may be made on other grounds.
D. Fair evidence (at least 1 properly conducted randomized controlled trial) to support the recommendation that the alternative be specifically excluded from consideration.
E. Good evidence (evidence from well designed controlled trials without randomization, from well designed cohort or case control studies, comparisons between times and places) the recommendation that the alternative be specifically excluded from consideration.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Correction of visual impairment
- Maintenance of quality of life
- Prevention of progression of cataract

Subgroups Most Likely to Benefit

Patients with no ocular or medical co-morbidities

POTENTIAL HARMS

Lacrimal Apparatus Irrigation

One study has questioned the routine performance of lacrimal apparatus irrigation because in some instances it has led to worsening of the microbial flora and graver infection.

Surgical Complications of Cataract Extraction Procedures

- Vitreous loss
- Retinal detachment
- Intraocular lens malposition or dislocation
- Poor visual outcome (poor visual acuity)
- Postoperative inflammation or endophthalmitis
- Intraocular iris trauma
- Residual posterior capsular opacity
- Postoperative corneal edema
- Atonic pupils

Complications of Intraocular Lens Implants

- In general, studies have shown the similarity of silicone, acrylic and polymethylmethacrylate (PMMA) lens implants in terms of post-operative inflammation, displacement, and rate of astigmatism.
- One randomized, prospective trial showed that patients with polyacrylic intraocular lens implants were less likely to require Nd:YAG capsulotomy and at three years, polyacrylic lens were also associated with less posterior capsule opacification compared to polymethylmethacrylate and silicone.
- Another randomized, prospective trial showed hydrogel lens implants were associated with a higher degree of posterior capsule opacification and laser capsulotomies than polymethylmethacrylate and silicone lens.

Anesthesia Side Effects

- One study reported a higher incidence of nausea and sore throat with general anesthesia compared with local anesthesia; however, eye bruising was higher with local anesthesia.
- One prospectively randomized study showed that topical anesthesia was associated with significantly more discomfort both during administration of anesthesia and post-operatively.

Subgroups Most Likely to Be Harmed

Patients with ocular or medical co-morbidities (e.g., high myopia, diabetes mellitus)

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Dissemination will be done by publishing the guideline and making it available via the Internet. The Philippine Academy of Ophthalmology and Family Medicine Research Group will be responsible to disseminate the guidelines to other ophthalmologists, family medicine specialists, and general practitioners via an interactive lecture workshop session.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Philippine Academy of Ophthalmology. Clinical practice guideline for the management of cataract among adults. Philippines: Philippine Academy of Ophthalmology; 2001. 27 p. [73 references]

Philippine Academy of Ophthalmology. Clinical practice guidelines for the management of cataract among adults. Updated recommendation #14. Philipp J Ophthalmol 2005 Apr-Jun;30(2):95-6. [9 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 (addendum released 2005)

GUIDELINE DEVELOPER(S)

Family Medicine Research Group, UP-PGH - Academic Institution
Philippine Academy of Ophthalmology - Medical Specialty Society

GUIDELINE DEVELOPER COMMENT

The development of this clinical practice guideline was a joint project of the Philippine Academy of Ophthalmology, and the Family Medicine Research Group of UP-PGH, Manila.

SOURCE(S) OF FUNDING

The Philippine Health Insurance Corporation and the Christoffel-Blindenmission provided financial assistance. However, the Philippine Health Insurance Corporation and the Christoffel-Blindenmission did not exert any influence in the formulation of this guideline.

GUIDELINE COMMITTEE

Ad Hoc Committee on Clinical Practice Guidelines 2001, chaired by Jacqueline Hernandez-King, MD

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The authors declare that they have no competing financial interests.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Philippine Academy of Ophthalmology Web site.

Print copies: Available from the Philippine Academy of Ophthalmology, 3rd floor Philippine College of Surgeon's Bldg, 992 North Edsa 1105 Quezon City, Metro Manila, Philippines; Tel. (632) 9253789.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EBO technical review of the validity of Recommendation #14 of the Clinical Practice Guidelines for the Management of Cataract among Adults. Philipp J Ophthalmol. 2005;30(2):92-94. Electronic copies: Available in Portable Document Format (PDF) from the Philippine Academy of Ophthalmology Web site.
- Clinical Practice Guidelines for the Management of Cataract among Adults. Update Recommendation #14. Appendix. Philipp J. Ophthalmol. 2005;30(2):95-96. Electronic copies: Available in Portable Document Format (PDF) from the Philippine Academy of Ophthalmology Web site.

Print copies: Available from the Philippine Academy of Ophthalmology, Unit 815 Medical Plaza Makati, Amorsolo St., corner De la Rosa St., Makati City, Philippines; Phone: (632) 813-5318; E-mail: pao@pao.org.ph.

PATIENT RESOURCES

The following is available:

- The truth about cataract surgery. Philippines: Philippine Academy of Ophthalmology, 1 p.

Print copies: Available from the Philippine Academy of Ophthalmology, Unit 815 Medical Plaza Makati, Amorsolo St., corner De la Rosa St., Makati City, Philippines; Phone: (632) 813-5318; E-mail: pao@pao.org.ph.

NGC STATUS

This summary was completed by ECRI on February 26, 2002. The information was verified by the guideline developer as of April 11, 2002. This summary was updated on May 3, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This NGC summary was updated to include the

addendum on October 24, 2005. The updated information was verified by the guideline developer on November 28, 2005.

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